allenton dental | all smiles

Getting to know you…

Our patient history and information questionnaire

Name .....

Date of birth .....

Contact telephone number .....

Email address .....

Your GP's name and address .....

.....

.....

Your medical history

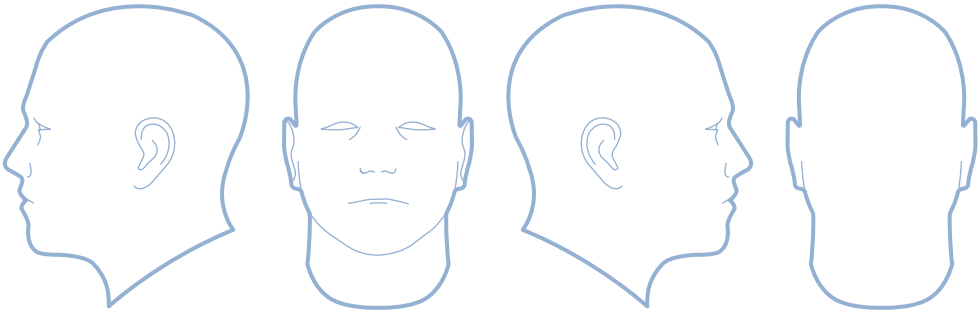
	Y	N	Comment
Are you attending/receiving treatment (or have in the past) from a doctor, hospital, clinic or specialist?			
Are you taking any medicines, tablets, drugs or injections, or using any cream, ointment or inhaler?			
Are you taking or have you taken steroids in the last 2 years?			
Are you allergic to any medicine, food or materials (e.g. latex) or suffer from hay fever?			
Do you carry a warning card?			
Are you pregnant or a nursing mother?			
Have you ever been diagnosed with any of the following? · HIV · Rheumatic fever or chorea · Heart condition or murmur, high blood pressure or pacemaker · Blood disorder · Excessive bleeding · Bronchitis, asthma or other chest condition · Fainting attacks, giddiness, blackouts or epilepsy · Diabetes · Jaundice, liver or kidney disease · Hepatitis · CJD			
Have you ever had a stroke?			
Have you had a joint replacement or other implant?			
Have you ever had a bad reaction to a local or general anesthetic?			
Are there any other aspects, concerning your health that your dentist should know about?			

	Number
On average, how many cigarettes do you smoke per day?	
On average, how many units of alcohol do you consume per day?	

Your jaw and bite

	Y	N
Have you ever been diagnosed with a problem with either jaw joint?		
Does your jaw joint click, pop or make noise when you open and close it?		
Do you have pain or tenderness in your jaw joint when you open, close or chew?		
Has your jaw ever locked open or closed?		
Have you ever had a bite splint or mouth guard made for you?		
Do you have a history of trauma to your chin or jaw, such as a blow to the face or a car accident?		
Do you have headaches, neck or back problems?		
Are you being treated by an osteopath, chiropractor or physical therapist?		
Do you suffer from a movement disorder (tic) or have you been diagnosed as having Tourette's Syndrome?		
Have you undergone orthodontic treatment?		
Have you experienced broken, sensitive or worn teeth?		
Do you have or have you been told you clench and/or grind your teeth?		

Do you suffer any pain or headache symptoms?
If yes, please indicate the location/s on the diagrams below:



Left side **Front** **Right side** **Back**

Our smile survey

	Y	N
Do your gums ever bleed?		
Do you have any missing teeth?		
Are you concerned about the appearance of your smile?		
Have you noticed your teeth getting shorter?		
Have you noticed your teeth getting darker?		
Do you like the alignment of your teeth?		
Do you have fillings in your back teeth?		
Are you happy with the colour of your fillings?		
Do you play any contact sport?		
Does your breath have an odour?		
Are you ever sleepy during the day?		
Do you snore at night?		
Are you confident to smile?		

Patient signature

Dentist signature

Today's date

allenton dental

BDA goodpractice

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